North Carolina Medicaid — MEDICATION THERAPY MANAGEMENT PROGRAM (Page 1)
Patient Medication Profile*

Patient Information

Patient Name:		Medicaid ID#:		Date of Birth:	
Primary Care Physician Name:		Prescriber Phone:		Prescriber Fax:	
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	

Is the patient known to be allergic to any medications? ☐Yes ☐No; If yes, please list: _____

Medication Profile: Complete all information for each line. Include all medications the patient is taking, including known OTC, Herbal, and non-routine (e.g., PRN) products. If necessary, additional pages may be attached.

	Start Date	Medication Name/Strength/Quantity	Regimen(dosage/route/times per day)	Purpose for use(Diagnosis if available)	Prescribing Physician and contact information	Precautions/Warnings	Stop date
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							

Date Prepared: _____ RPh Reviewer: _____

* Pharmacy may substitute their computer generated profile if it contains all of the required information listed, including medication related diagnosis.

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Rev.6/2006

North Carolina Medicaid — MEDICATION THERAPY MANAGEMENT PROGRAM (Page 2)
Medication Review Communication Form

TO: (Primary Care Physician):_____ **Date:**_____
Fax: _____ **Phone:** _____

From: (Pharmacy):_____ **Phone:**_____ **Fax:**_____

Patient Name:_____ **Medicaid ID #:** _____

Prescription Issues: Based on review of the recipient's medication profile (page 1), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. **Please provide a response for every recommended action.**

Medication Related Issues Identified	Recommended Plan of Action	PCP Response and Comments
❑ Medication Dose/Frequency/Duration ❑ Adverse Drug Event ❑ Therapeutic Duplication ❑ Drug/Drug Interaction ❑ Drug/Disease Interaction ❑ Drug/Food Interaction ❑ Discontinued Medication ❑ Medication Compliance ❑ Contraindication ❑ Drug Allergy ❑ Other; _____	1. 2. 3. 4.	1. Accept Recommendation ☐Yes ☐No Comment: 2. Accept Recommendation ☐Yes ☐No Comment: 3. Accept Recommendation ☐Yes ☐No Comment: 4. Accept Recommendation ☐Yes ☐No Comment:

Cost-Effective Recommendations

❑ Dose Consolidation ❑ Dose Optimization ❑ Generic Alternative ❑ Other; _____	1. 2.	1. Accept Recommendation ☐Yes ☐No Comment: 2. Accept Recommendation ☐Yes ☐No Comment:

Patient Specific Education Provided:_____

Comments:_____

Time Spent with Patient:_____**Scheduled plan for follow-up appointment:**_____
Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: _____ **RPh Reviewer:** _____
Date: _____ **Primary Care Physician:** _____

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